

House Engrossed

State of Arizona
House of Representatives
Forty-fifth Legislature
Second Regular Session
2002

CHAPTER 57

HOUSE BILL 2234

AN ACT

AMENDING SECTION 20-826, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 4, ARTICLE 9, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1057.08; AMENDING SECTIONS 20-1402 AND 20-1404, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 13, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-2329; RELATING TO HEALTH CARE INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 20-826, Arizona Revised Statutes, is amended to read:

20-826. Subscription contracts; definitions

A. A contract between a corporation and its subscribers shall not be issued unless the form of such contract is approved in writing by the director.

B. Each contract shall plainly state the services to which the subscriber is entitled and those to which the subscriber is not entitled under the plan, and shall constitute a direct obligation of the providers of services with which the corporation has contracted for hospital, medical, dental or optometric services.

C. Each contract, except for dental services or optometric services, shall be so written that the corporation shall pay benefits for each of the following:

1. Performance of any surgical service that is covered by the terms of such contract, regardless of the place of service.

2. Any home health services that are performed by a licensed home health agency and that a physician has prescribed in lieu of hospital services, as defined by the director, providing the hospital services would have been covered.

3. Any diagnostic service that a physician has performed outside a hospital in lieu of inpatient service, providing the inpatient service would have been covered.

4. Any service performed in a hospital's outpatient department or in a freestanding surgical facility, if such service would have been covered if performed as an inpatient service.

D. Each contract for dental or optometric services shall be so written that the corporation shall pay benefits for contracted dental or optometric services provided by dentists or optometrists.

E. Any contract, except accidental death and dismemberment, applied for that provides family coverage shall, as to such coverage of family members, also provide that the benefits applicable for children shall be payable with respect to a newly born child of the insured from the instant of such child's birth, to a child adopted by the insured, regardless of the age at which the child was adopted, and to a child who has been placed for adoption with the insured and for whom the application and approval procedures for adoption pursuant to section 8-105 or 8-108 have been completed to the same extent that such coverage applies to other members of the family. The coverage for newly born or adopted children or children placed for adoption shall include coverage of injury or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the contract may require that notification of birth, adoption or adoption placement of the child and payment of the required

1 premium must be furnished to the insurer within thirty-one days after the
2 date of birth, adoption or adoption placement in order to have the coverage
3 continue beyond the thirty-one day period.

4 F. Each contract that is delivered or issued for delivery in this
5 state after December 25, 1977 and that provides that coverage of a dependent
6 child shall terminate upon attainment of the limiting age for dependent
7 children specified in the contract shall also provide in substance that
8 attainment of such limiting age shall not operate to terminate the coverage
9 of such child while the child is and continues to be both incapable of
10 self-sustaining employment by reason of mental retardation or physical
11 handicap and chiefly dependent upon the subscriber for support and
12 maintenance. Proof of such incapacity and dependency shall be furnished to
13 the corporation by the subscriber within thirty-one days of the child's
14 attainment of the limiting age and subsequently as may be required by the
15 corporation, but not more frequently than annually after the two-year period
16 following the child's attainment of the limiting age.

17 G. No corporation may cancel or refuse to renew any subscriber's
18 contract without giving notice of such cancellation or nonrenewal to the
19 subscriber under such contract. A notice by the corporation to the
20 subscriber of cancellation or nonrenewal of a subscription contract shall be
21 mailed to the named subscriber at least forty-five days before the effective
22 date of such cancellation or nonrenewal. The notice shall include or be
23 accompanied by a statement in writing of the reasons for such action by the
24 corporation. Failure of the corporation to comply with the provisions of
25 this subsection shall invalidate any cancellation or nonrenewal except a
26 cancellation or nonrenewal for nonpayment of premium.

27 H. A contract that provides coverage for surgical services for a
28 mastectomy shall also provide coverage incidental to the patient's covered
29 mastectomy for surgical services for reconstruction of the breast on which
30 the mastectomy was performed, surgery and reconstruction of the other breast
31 to produce a symmetrical appearance, prostheses, treatment of physical
32 complications for all stages of the mastectomy, including lymphedemas, and
33 at least two external postoperative prostheses subject to all of the terms
34 and conditions of the policy.

35 I. A contract that provides coverage for surgical services for a
36 mastectomy shall also provide coverage for mammography screening performed
37 on dedicated equipment for diagnostic purposes on referral by a patient's
38 physician, subject to all of the terms and conditions of the policy and
39 according to the following guidelines:

40 1. A baseline mammogram for a woman from age thirty-five to
41 thirty-nine.

42 2. A mammogram for a woman from age forty to forty-nine every two
43 years or more frequently based on the recommendation of the woman's
44 physician.

45 3. A mammogram every year for a woman fifty years of age and over.

1 J. Any contract that is issued to the insured and that provides
2 coverage for maternity benefits shall also provide that the maternity
3 benefits apply to the costs of the birth of any child legally adopted by the
4 insured if all of the following are true:

- 5 1. The child is adopted within one year of birth.
- 6 2. The insured is legally obligated to pay the costs of birth.
- 7 3. All preexisting conditions and other limitations have been met by
8 the insured.

9 4. The insured has notified the insurer of the insured's acceptability
10 to adopt children pursuant to section 8-105, within sixty days after such
11 approval or within sixty days after a change in insurance policies, plans or
12 companies.

13 K. The coverage prescribed by subsection J of this section is excess
14 to any other coverage the natural mother may have for maternity benefits
15 except coverage made available to persons pursuant to title 36, chapter 29
16 but not including coverage made available to persons defined as eligible
17 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If
18 such other coverage exists the agency, attorney or individual arranging the
19 adoption shall make arrangements for the insurance to pay those costs that
20 may be covered under that policy and shall advise the adopting parent in
21 writing of the existence and extent of the coverage without disclosing any
22 confidential information such as the identity of the natural parent. The
23 insured adopting parents shall notify their insurer of the existence and
24 extent of the other coverage.

25 L. The director may disapprove any contract if the benefits provided
26 in the form of such contract are unreasonable in relation to the premium
27 charged.

28 M. The director shall adopt emergency rules applicable to persons who
29 are leaving active service in the armed forces of the United States and
30 returning to civilian status including:

- 31 1. Conditions of eligibility.
- 32 2. Coverage of dependents.
- 33 3. Preexisting conditions.
- 34 4. Termination of insurance.
- 35 5. Probationary periods.
- 36 6. Limitations.
- 37 7. Exceptions.
- 38 8. Reductions.
- 39 9. Elimination periods.
- 40 10. Requirements for replacement.
- 41 11. Any other condition of subscription contracts.

42 N. Any contract that provides maternity benefits shall not restrict
43 benefits for any hospital length of stay in connection with childbirth for
44 the mother or the newborn child to less than forty-eight hours following a
45 normal vaginal delivery or ninety-six hours following a cesarean

1 section. The contract shall not require the provider to obtain authorization
2 from the corporation for prescribing the minimum length of stay required by
3 this subsection. The contract may provide that an attending provider in
4 consultation with the mother may discharge the mother or the newborn child
5 before the expiration of the minimum length of stay required by this
6 subsection. The corporation shall not:

7 1. Deny the mother or the newborn child eligibility or continued
8 eligibility to enroll or to renew coverage under the terms of the contract
9 solely for the purpose of avoiding the requirements of this subsection.

10 2. Provide monetary payments or rebates to mothers to encourage those
11 mothers to accept less than the minimum protections available pursuant to
12 this subsection.

13 3. Penalize or otherwise reduce or limit the reimbursement of an
14 attending provider because that provider provided care to any insured under
15 the contract in accordance with this subsection.

16 4. Provide monetary or other incentives to an attending provider to
17 induce that provider to provide care to an insured under the contract in a
18 manner that is inconsistent with this subsection.

19 5. Except as described in subsection O of this section, restrict
20 benefits for any portion of a period within the minimum length of stay in a
21 manner that is less favorable than the benefits provided for any preceding
22 portion of that stay.

23 O. Nothing in subsection N of this section:

24 1. Requires a mother to give birth in a hospital or to stay in the
25 hospital for a fixed period of time following the birth of the child.

26 2. Prevents a corporation from imposing deductibles, coinsurance or
27 other cost sharing in relation to benefits for hospital lengths of stay in
28 connection with childbirth for a mother or a newborn child under the
29 contract, except that any coinsurance or other cost sharing for any portion
30 of a period within a hospital length of stay required pursuant to subsection
31 N of this section shall not be greater than the coinsurance or cost sharing
32 for any preceding portion of that stay.

33 3. Prevents a corporation from negotiating the level and type of
34 reimbursement with a provider for care provided in accordance with subsection
35 N of this section.

36 P. Any contract that provides coverage for diabetes shall also provide
37 coverage for equipment and supplies that are medically necessary and that are
38 prescribed by a health care provider including:

39 1. Blood glucose monitors.

40 2. Blood glucose monitors for the legally blind.

41 3. Test strips for glucose monitors and visual reading and urine
42 testing strips.

43 4. Insulin preparations and glucagon.

44 5. Insulin cartridges.

45 6. Drawing up devices and monitors for the visually impaired.

1 7. Injection aids.

2 8. Insulin cartridges for the legally blind.

3 9. Syringes and lancets including automatic lancing devices.

4 10. Prescribed oral agents for controlling blood sugar that are
5 included on the plan formulary.

6 11. To the extent coverage is required under medicare, podiatric
7 appliances for prevention of complications associated with diabetes.

8 12. Any other device, medication, equipment or supply for which
9 coverage is required under medicare from and after January 1, 1999. The
10 coverage required in this paragraph is effective six months after the
11 coverage is required under medicare.

12 Q. Nothing in subsection P of this section prohibits a medical service
13 corporation, a hospital service corporation or a hospital, medical, dental
14 and optometric service corporation from imposing deductibles, coinsurance or
15 other cost sharing in relation to benefits for equipment or supplies for the
16 treatment of diabetes.

17 R. Any hospital or medical service contract that provides coverage for
18 prescription drugs shall not limit or exclude coverage for any prescription
19 drug prescribed for the treatment of cancer on the basis that the
20 prescription drug has not been approved by the United States food and drug
21 administration for the treatment of the specific type of cancer for which the
22 prescription drug has been prescribed, if the prescription drug has been
23 recognized as safe and effective for treatment of that specific type of
24 cancer in one or more of the standard medical reference compendia prescribed
25 in subsection S of this section or medical literature that meets the criteria
26 prescribed in subsection S of this section. The coverage required under this
27 subsection includes covered medically necessary services associated with the
28 administration of the prescription drug. This subsection does not:

29 1. Require coverage of any prescription drug used in the treatment of
30 a type of cancer if the United States food and drug administration has
31 determined that the prescription drug is contraindicated for that type of
32 cancer.

33 2. Require coverage for any experimental prescription drug that is not
34 approved for any indication by the United States food and drug
35 administration.

36 3. Alter any law with regard to provisions that limit the coverage of
37 prescription drugs that have not been approved by the United States food and
38 drug administration.

39 4. Notwithstanding section 20-841.05, require reimbursement or
40 coverage for any prescription drug that is not included in the drug formulary
41 or list of covered prescription drugs specified in the contract.

42 5. Notwithstanding section 20-841.05, prohibit a contract from
43 limiting or excluding coverage of a prescription drug, if the decision to
44 limit or exclude coverage of the prescription drug is not based primarily on
45 the coverage of prescription drugs required by this section.

1 6. Prohibit the use of deductibles, coinsurance, copayments or other
2 cost sharing in relation to drug benefits and related medical benefits
3 offered.

4 S. For the purposes of subsection R of this section:

5 1. The acceptable standard medical reference compendia are the
6 following:

7 (a) The American medical association drug evaluations, a publication
8 of the American medical association.

9 (b) The American hospital formulary service drug information, a
10 publication of the American society of health system pharmacists.

11 (c) Drug information for the health care provider, a publication of
12 the United States pharmacopoeia convention.

13 2. Medical literature may be accepted if all of the following apply:

14 (a) At least two articles from major peer reviewed professional
15 medical journals have recognized, based on scientific or medical criteria,
16 the drug's safety and effectiveness for treatment of the indication for which
17 the drug has been prescribed.

18 (b) No article from a major peer reviewed professional medical journal
19 has concluded, based on scientific or medical criteria, that the drug is
20 unsafe or ineffective or that the drug's safety and effectiveness cannot be
21 determined for the treatment of the indication for which the drug has been
22 prescribed.

23 (c) The literature meets the uniform requirements for manuscripts
24 submitted to biomedical journals established by the international committee
25 of medical journal editors or is published in a journal specified by the
26 United States department of health and human services as acceptable peer
27 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
28 security act (42 United States Code section 1395x(t)(2)(B)).

29 T. A corporation shall not issue or deliver any advertising matter or
30 sales material to any person in this state until the corporation files the
31 advertising matter or sales material with the director. This subsection does
32 not require a corporation to have the prior approval of the director to issue
33 or deliver the advertising matter or sales material. If the director finds
34 that the advertising matter or sales material, in whole or in part, is false,
35 deceptive or misleading, the director may issue an order disapproving the
36 advertising matter or sales material, directing the corporation to cease and
37 desist from issuing, circulating, displaying or using the advertising matter
38 or sales material within a period of time specified by the director but not
39 less than ten days and imposing any penalties prescribed in this title. At
40 least five days before issuing an order pursuant to this subsection, the
41 director shall provide the corporation with a written notice of the basis of
42 the order to provide the corporation with an opportunity to cure the alleged
43 deficiency in the advertising matter or sales material within a single five
44 day period for the particular advertising matter or sales material at
45 issue. The corporation may appeal the director's order pursuant to title 41,

chapter 6, article 10. Except as otherwise provided in this subsection, a corporation may obtain a stay of the effectiveness of the order as prescribed in section 20-162. If the director certifies in the order and provides a detailed explanation of the reasons in support of the certification that continued use of the advertising matter or sales material poses a threat to the health, safety or welfare of the public, the order may be entered immediately without opportunity for cure and the effectiveness of the order is not stayed pending the hearing on the notice of appeal but the hearing shall be promptly instituted and determined.

U. Any contract that is offered by a hospital service corporation or medical service corporation and that contains a prescription drug benefit shall provide coverage of medical foods to treat inherited metabolic disorders as provided by this section.

V. The metabolic disorders triggering medical foods coverage under this section shall:

1. Be part of the newborn screening program prescribed in section 36-694.

2. Involve amino acid, carbohydrate or fat metabolism.

3. Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues.

4. Require specially processed or treated medical foods that are generally available only under the supervision and direction of a physician who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

W. Medical foods eligible for coverage under this section shall be prescribed or ordered under the supervision of a physician licensed pursuant to title 32, chapter 13 or 17 as medically necessary for the therapeutic treatment of an inherited metabolic disease.

X. A hospital service corporation or medical service corporation shall cover at least fifty per cent of the cost of medical foods prescribed to treat inherited metabolic disorders and covered pursuant to this section. A hospital service corporation or medical service corporation may limit the maximum annual benefit for medical foods under this section to five thousand dollars, which applies to the cost of all prescribed modified low protein foods and metabolic formula.

Y. ANY CONTRACT BETWEEN A CORPORATION AND ITS SUBSCRIBERS IS SUBJECT TO THE FOLLOWING:

1. IF THE CONTRACT PROVIDES COVERAGE FOR PRESCRIPTION DRUGS, THE CONTRACT SHALL PROVIDE COVERAGE FOR ANY PRESCRIBED DRUG OR DEVICE THAT IS APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION FOR USE AS A CONTRACEPTIVE. A CORPORATION MAY USE A DRUG FORMULARY, MULTITIERED DRUG FORMULARY OR LIST BUT THAT FORMULARY OR LIST SHALL INCLUDE ORAL, IMPLANT AND INJECTABLE CONTRACEPTIVE DRUGS, INTRAUTERINE DEVICES AND PRESCRIPTION BARRIER

1 METHODS IF THE CORPORATION DOES NOT IMPOSE DEDUCTIBLES, COINSURANCE,
2 COPAYMENTS OR OTHER COST CONTAINMENT MEASURES FOR CONTRACEPTIVE DRUGS THAT
3 ARE GREATER THAN THE DEDUCTIBLES, COINSURANCE, COPAYMENTS OR OTHER COST
4 CONTAINMENT MEASURES FOR OTHER DRUGS ON THE SAME LEVEL OF THE FORMULARY OR
5 LIST.

6 2. IF THE CONTRACT PROVIDES COVERAGE FOR OUTPATIENT HEALTH CARE
7 SERVICES, THE CONTRACT SHALL PROVIDE COVERAGE FOR OUTPATIENT CONTRACEPTIVE
8 SERVICES. FOR THE PURPOSES OF THIS PARAGRAPH, "OUTPATIENT CONTRACEPTIVE
9 SERVICES" MEANS CONSULTATIONS, EXAMINATIONS, PROCEDURES AND MEDICAL SERVICES
10 PROVIDED ON AN OUTPATIENT BASIS AND RELATED TO THE USE OF UNITED STATES FOOD
11 AND DRUG PRESCRIPTION CONTRACEPTIVE METHODS TO PREVENT UNINTENDED
12 PREGNANCIES.

13 3. THIS SUBSECTION DOES NOT APPLY TO CONTRACTS ISSUED TO INDIVIDUALS
14 ON A NONGROUP BASIS.

15 2. NOTWITHSTANDING SUBSECTION Y OF THIS SECTION, A RELIGIOUS EMPLOYER
16 WHOSE RELIGIOUS TENETS PROHIBIT THE USE OF PRESCRIBED CONTRACEPTIVE METHODS
17 MAY REQUIRE THAT THE CORPORATION PROVIDE A CONTRACT WITHOUT COVERAGE FOR ALL
18 FEDERAL FOOD AND DRUG ADMINISTRATION APPROVED CONTRACEPTIVE METHODS. A
19 RELIGIOUS EMPLOYER SHALL SUBMIT A WRITTEN AFFIDAVIT TO THE CORPORATION
20 STATING THAT IT IS A RELIGIOUS EMPLOYER. ON RECEIPT OF THE AFFIDAVIT, THE
21 CORPORATION SHALL ISSUE TO THE RELIGIOUS EMPLOYER A CONTRACT THAT EXCLUDES
22 COVERAGE OF PRESCRIPTION CONTRACEPTIVE METHODS. THE CORPORATION SHALL RETAIN
23 THE AFFIDAVIT FOR THE DURATION OF THE CONTRACT AND ANY RENEWALS OF THE
24 CONTRACT. BEFORE ENROLLMENT IN THE PLAN, EVERY RELIGIOUS EMPLOYER THAT
25 INVOKES THIS EXEMPTION SHALL PROVIDE PROSPECTIVE SUBSCRIBERS WRITTEN NOTICE
26 THAT THE RELIGIOUS EMPLOYER REFUSES TO COVER ALL FEDERAL FOOD AND DRUG
27 ADMINISTRATION APPROVED CONTRACEPTIVE METHODS FOR RELIGIOUS REASONS. THIS
28 SUBSECTION SHALL NOT EXCLUDE COVERAGE FOR PRESCRIPTION CONTRACEPTIVE METHODS
29 ORDERED BY A HEALTH CARE PROVIDER WITH PRESCRIPTIVE AUTHORITY FOR MEDICAL
30 INDICATIONS OTHER THAN TO PREVENT AN UNINTENDED PREGNANCY. A CORPORATION MAY
31 REQUIRE THE SUBSCRIBER TO FIRST PAY FOR THE PRESCRIPTION AND THEN SUBMIT A
32 CLAIM TO THE CORPORATION ALONG WITH EVIDENCE THAT THE PRESCRIPTION IS FOR A
33 NONCONTRACEPTIVE PURPOSE. A CORPORATION MAY CHARGE AN ADMINISTRATIVE FEE FOR
34 HANDLING THESE CLAIMS. A RELIGIOUS EMPLOYER SHALL NOT DISCRIMINATE AGAINST
35 AN EMPLOYEE WHO INDEPENDENTLY CHOOSES TO OBTAIN INSURANCE COVERAGE OR
36 PRESCRIPTIONS FOR CONTRACEPTIVES FROM ANOTHER SOURCE.

37 Y. AA. For the purposes of:

38 1. This section:

39 (a) "Inherited metabolic disorder" means a disease caused by an
40 inherited abnormality of body chemistry and includes a disease tested under
41 the newborn screening program prescribed in section 36-694.

42 (b) "Medical foods" means modified low protein foods and metabolic
43 formula.

44 (c) "Metabolic formula" means foods that are all of the following:

1 (i) Formulated to be consumed or administered enterally under the
2 supervision of a physician who is licensed pursuant to title 32, chapter 13
3 or 17.

4 (ii) Processed or formulated to be deficient in one or more of the
5 nutrients present in typical foodstuffs.

6 (iii) Administered for the medical and nutritional management of a
7 person who has limited capacity to metabolize foodstuffs or certain nutrients
8 contained in the foodstuffs or who has other specific nutrient requirements
9 as established by medical evaluation.

10 (iv) Essential to a person's optimal growth, health and metabolic
11 homeostasis.

12 (d) "Modified low protein foods" means foods that are all of the
13 following:

14 (i) Formulated to be consumed or administered enterally under the
15 supervision of a physician who is licensed pursuant to title 32, chapter 13
16 or 17.

17 (ii) Processed or formulated to contain less than one gram of protein
18 per unit of serving, but does not include a natural food that is naturally
19 low in protein.

20 (iii) Administered for the medical and nutritional management of a
21 person who has limited capacity to metabolize foodstuffs or certain nutrients
22 contained in the foodstuffs or who has other specific nutrient requirements
23 as established by medical evaluation.

24 (iv) Essential to a person's optimal growth, health and metabolic
25 homeostasis.

26 2. Subsection E of this section, the term "child", for purposes of
27 initial coverage of an adopted child or a child placed for adoption but not
28 for purposes of termination of coverage of such child, means a person under
29 the age of eighteen years.

30 3. SUBSECTION Z OF THIS SECTION, "RELIGIOUS EMPLOYER" MEANS AN ENTITY
31 FOR WHICH ALL OF THE FOLLOWING APPLY:

32 (a) THE ENTITY PRIMARILY EMPLOYS PERSONS WHO SHARE THE RELIGIOUS
33 TENETS OF THE ENTITY.

34 (b) THE ENTITY PRIMARILY SERVES PERSONS WHO SHARE THE RELIGIOUS TENETS
35 OF THE ENTITY.

36 (c) THE ENTITY IS A NONPROFIT ORGANIZATION AS DESCRIBED IN SECTION
37 6033(a)(2)(A)i OR iii OF THE INTERNAL REVENUE CODE OF 1986, AS AMENDED.

38 Sec. 2. Title 20, chapter 4, article 9, Arizona Revised Statutes, is
39 amended by adding section 20-1057.08, to read:

40 20-1057.08. Prescription contraceptive drugs and devices;
41 definition

42 A. IF A HEALTH CARE SERVICES ORGANIZATION ISSUES EVIDENCE OF COVERAGE
43 THAT PROVIDES COVERAGE FOR:

44 1. PRESCRIPTION DRUGS, THE EVIDENCE OF COVERAGE SHALL PROVIDE COVERAGE
45 FOR ANY PRESCRIBED DRUG OR DEVICE THAT IS APPROVED BY THE UNITED STATES FOOD

1 AND DRUG ADMINISTRATION FOR USE AS A CONTRACEPTIVE. A HEALTH CARE SERVICES
2 ORGANIZATION MAY USE A DRUG FORMULARY, MULTITIERED DRUG FORMULARY OR LIST BUT
3 THAT FORMULARY OR LIST SHALL INCLUDE ORAL, IMPLANT AND INJECTABLE
4 CONTRACEPTIVE DRUGS, INTRAUTERINE DEVICES AND PRESCRIPTION BARRIER METHODS
5 IF THE HEALTH CARE SERVICES ORGANIZATION DOES NOT IMPOSE DEDUCTIBLES,
6 COINSURANCE, COPAYMENTS OR OTHER COST CONTAINMENT MEASURES FOR CONTRACEPTIVE
7 DRUGS THAT ARE GREATER THAN THE DEDUCTIBLES, COINSURANCE, COPAYMENTS OR OTHER
8 COST CONTAINMENT MEASURES FOR OTHER DRUGS ON THE SAME LEVEL OF THE FORMULARY
9 OR LIST.

10 2. OUTPATIENT HEALTH CARE SERVICES, THE EVIDENCE OF COVERAGE SHALL
11 PROVIDE COVERAGE FOR OUTPATIENT CONTRACEPTIVE SERVICES. FOR THE PURPOSES OF
12 THIS PARAGRAPH, "OUTPATIENT CONTRACEPTIVE SERVICES" MEANS CONSULTATIONS,
13 EXAMINATIONS, PROCEDURES AND MEDICAL SERVICES PROVIDED ON AN OUTPATIENT BASIS
14 AND RELATED TO THE USE OF UNITED STATES FOOD AND DRUG PRESCRIPTION
15 CONTRACEPTIVE METHODS TO PREVENT UNINTENDED PREGNANCIES.

16 3. THIS SECTION DOES NOT APPLY TO EVIDENCES OF COVERAGE ISSUED TO
17 INDIVIDUALS ON A NONGROUP BASIS.

18 B. NOTWITHSTANDING SUBSECTION A, A RELIGIOUS EMPLOYER WHOSE RELIGIOUS
19 TENETS PROHIBIT THE USE OF PRESCRIBED CONTRACEPTIVE METHODS MAY REQUIRE THAT
20 THE HEALTH CARE SERVICES ORGANIZATION PROVIDE COVERAGE THAT EXCLUDES ALL
21 FEDERAL FOOD AND DRUG ADMINISTRATION APPROVED CONTRACEPTIVE METHODS. A
22 RELIGIOUS EMPLOYER SHALL SUBMIT A WRITTEN AFFIDAVIT TO THE HEALTH CARE
23 SERVICES ORGANIZATION STATING THAT IT IS A RELIGIOUS EMPLOYER. ON RECEIPT OF
24 THE AFFIDAVIT, THE HEALTH CARE SERVICES ORGANIZATION SHALL PROVIDE COVERAGE
25 TO THE RELIGIOUS EMPLOYER THAT EXCLUDES PRESCRIPTION CONTRACEPTIVE METHODS.
26 THE HEALTH CARE SERVICES ORGANIZATION SHALL RETAIN THE AFFIDAVIT FOR THE
27 DURATION OF THE COVERAGE AND ANY RENEWALS OF THE COVERAGE.

28 C. BEFORE ENROLLMENT IN THE HEALTH CARE PLAN, EVERY RELIGIOUS EMPLOYER
29 THAT INVOKES THIS EXEMPTION SHALL PROVIDE PROSPECTIVE ENROLLEES WRITTEN
30 NOTICE THAT THE RELIGIOUS EMPLOYER REFUSES TO COVER ALL FEDERAL FOOD AND DRUG
31 ADMINISTRATION APPROVED CONTRACEPTIVE METHODS FOR RELIGIOUS REASONS.

32 D. SUBSECTION B DOES NOT EXCLUDE COVERAGE FOR PRESCRIPTION
33 CONTRACEPTIVE METHODS ORDERED BY A HEALTH CARE PROVIDER WITH PRESCRIPTIVE
34 AUTHORITY FOR MEDICAL INDICATIONS OTHER THAN TO PREVENT AN UNINTENDED
35 PREGNANCY. A HEALTH CARE SERVICES ORGANIZATION MAY REQUIRE THE ENROLLEE TO
36 FIRST PAY FOR THE PRESCRIPTION AND THEN SUBMIT A CLAIM TO THE HEALTH CARE
37 SERVICES ORGANIZATION ALONG WITH EVIDENCE THAT THE PRESCRIPTION IS FOR A
38 NONCONTRACEPTIVE PURPOSE. A HEALTH CARE SERVICES ORGANIZATION MAY CHARGE AN
39 ADMINISTRATIVE FEE FOR HANDLING CLAIMS UNDER THIS SUBSECTION.

40 E. A RELIGIOUS EMPLOYER SHALL NOT DISCRIMINATE AGAINST AN EMPLOYEE WHO
41 INDEPENDENTLY CHOOSES TO OBTAIN INSURANCE COVERAGE OR PRESCRIPTIONS FOR
42 CONTRACEPTIVES FROM ANOTHER SOURCE.

43 F. FOR THE PURPOSES OF THIS SECTION, "RELIGIOUS EMPLOYER" MEANS AN
44 ENTITY FOR WHICH ALL OF THE FOLLOWING APPLY:

1 1. THE ENTITY PRIMARILY EMPLOYS PERSONS WHO SHARE THE RELIGIOUS TENETS
2 OF THE ENTITY.

3 2. THE ENTITY SERVES PRIMARILY PERSONS WHO SHARE THE RELIGIOUS TENETS
4 OF THE ENTITY.

5 3. THE ENTITY IS A NONPROFIT ORGANIZATION AS DESCRIBED IN SECTION
6 6033(a)(2)(A)i OR iii OF THE INTERNAL REVENUE CODE OF 1986, AS AMENDED.

7 Sec. 3. Section 20-1402, Arizona Revised Statutes, is amended to read:

8 20-1402. Provisions of group disability policies; definitions

9 A. Each group disability policy shall contain in substance the
10 following provisions:

11 1. A provision that, in the absence of fraud, all statements made by
12 the policyholder or by any insured person shall be deemed representations and
13 not warranties, and that no statement made for the purpose of effecting
14 insurance shall avoid such insurance or reduce benefits unless contained in
15 a written instrument signed by the policyholder or the insured person, a copy
16 of which has been furnished to the policyholder or to the person or
17 beneficiary.

18 2. A provision that the insurer will furnish to the policyholder, for
19 delivery to each employee or member of the insured group, an individual
20 certificate setting forth in summary form a statement of the essential
21 features of the insurance coverage of the employee or member and to whom
22 benefits are payable. If dependents or family members are included in the
23 coverage additional certificates need not be issued for delivery to the
24 dependents or family members. Any policy, except accidental death and
25 dismemberment, applied for that provides family coverage shall, as to such
26 coverage of family members, also provide that the benefits applicable for
27 children shall be payable with respect to a newly born child of the insured
28 from the instant of such child's birth, to a child adopted by the insured,
29 regardless of the age at which the child was adopted, and to a child who has
30 been placed for adoption with the insured and for whom the application and
31 approval procedures for adoption pursuant to section 8-105 or 8-108 have been
32 completed to the same extent that such coverage applies to other members of
33 the family. The coverage for newly born or adopted children or children
34 placed for adoption shall include coverage of injury or sickness including
35 the necessary care and treatment of medically diagnosed congenital defects
36 and birth abnormalities. If payment of a specific premium is required to
37 provide coverage for a child, the policy may require that notification of
38 birth, adoption or adoption placement of the child and payment of the
39 required premium must be furnished to the insurer within thirty-one days
40 after the date of birth, adoption or adoption placement in order to have the
41 coverage continue beyond such thirty-one day period.

42 3. A provision that to the group originally insured may be added from
43 time to time eligible new employees or members or dependents, as the case may
44 be, in accordance with the terms of the policy.

1 4. Each contract shall be so written that the corporation shall pay
2 benefits:

3 (a) For performance of any surgical service that is covered by the
4 terms of such contract, regardless of the place of service.

5 (b) For any home health services that are performed by a licensed
6 home health agency and that a physician has prescribed in lieu of hospital
7 services, as defined by the director, providing the hospital services would
8 have been covered.

9 (c) For any diagnostic service that a physician has performed outside
10 a hospital in lieu of inpatient service, providing the inpatient service
11 would have been covered.

12 (d) For any service performed in a hospital's outpatient department
13 or in a freestanding surgical facility, providing such service would have
14 been covered if performed as an inpatient service.

15 5. A group disability insurance policy that provides coverage for the
16 surgical expense of a mastectomy shall also provide coverage incidental to
17 the patient's covered mastectomy for the expense of reconstructive surgery
18 of the breast on which the mastectomy was performed, surgery and
19 reconstruction of the other breast to produce a symmetrical appearance,
20 prostheses, treatment of physical complications for all stages of the
21 mastectomy, including lymphedemas, and at least two external postoperative
22 prostheses subject to all of the terms and conditions of the policy.

23 6. A contract, except a supplemental contract covering a specified
24 disease or other limited benefits, that provides coverage for surgical
25 services for a mastectomy shall also provide coverage for mammography
26 screening performed on dedicated equipment for diagnostic purposes on
27 referral by a patient's physician, subject to all of the terms and conditions
28 of the policy and according to the following guidelines:

29 (a) A baseline mammogram for a woman from age thirty-five to
30 thirty-nine.

31 (b) A mammogram for a woman from age forty to forty-nine every two
32 years or more frequently based on the recommendation of the woman's
33 physician.

34 (c) A mammogram every year for a woman fifty years of age and over.

35 7. Any contract that is issued to the insured and that provides
36 coverage for maternity benefits shall also provide that the maternity
37 benefits apply to the costs of the birth of any child legally adopted by the
38 insured if all the following are true:

39 (a) The child is adopted within one year of birth.

40 (b) The insured is legally obligated to pay the costs of birth.

41 (c) All preexisting conditions and other limitations have been met by
42 the insured.

43 (d) The insured has notified the insurer of the insured's
44 acceptability to adopt children pursuant to section 8-105, within sixty days

1 after such approval or within sixty days after a change in insurance
2 policies, plans or companies.

3 8. The coverage prescribed by paragraph 7 of this subsection is
4 excess to any other coverage the natural mother may have for maternity
5 benefits except coverage made available to persons pursuant to title 36,
6 chapter 29, but not including coverage made available to persons defined as
7 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and
8 (e). If such other coverage exists the agency, attorney or individual
9 arranging the adoption shall make arrangements for the insurance to pay those
10 costs that may be covered under that policy and shall advise the adopting
11 parent in writing of the existence and extent of the coverage without
12 disclosing any confidential information such as the identity of the natural
13 parent. The insured adopting parents shall notify their insurer of the
14 existence and extent of the other coverage.

15 B. Any policy that provides maternity benefits shall not restrict
16 benefits for any hospital length of stay in connection with childbirth for
17 the mother or the newborn child to less than forty-eight hours following a
18 normal vaginal delivery or ninety-six hours following a cesarean
19 section. The policy shall not require the provider to obtain authorization
20 from the insurer for prescribing the minimum length of stay required by this
21 subsection. The policy may provide that an attending provider in
22 consultation with the mother may discharge the mother or the newborn child
23 before the expiration of the minimum length of stay required by this
24 subsection. The insurer shall not:

25 1. Deny the mother or the newborn child eligibility or continued
26 eligibility to enroll or to renew coverage under the terms of the policy
27 solely for the purpose of avoiding the requirements of this subsection.

28 2. Provide monetary payments or rebates to mothers to encourage those
29 mothers to accept less than the minimum protections available pursuant to
30 this subsection.

31 3. Penalize or otherwise reduce or limit the reimbursement of an
32 attending provider because that provider provided care to any insured under
33 the policy in accordance with this subsection.

34 4. Provide monetary or other incentives to an attending provider to
35 induce that provider to provide care to an insured under the policy in a
36 manner that is inconsistent with this subsection.

37 5. Except as described in subsection C of this section, restrict
38 benefits for any portion of a period within the minimum length of stay in a
39 manner that is less favorable than the benefits provided for any preceding
40 portion of that stay.

41 C. Nothing in subsection B of this section:

42 1. Requires a mother to give birth in a hospital or to stay in the
43 hospital for a fixed period of time following the birth of the child.

44 2. Prevents an insurer from imposing deductibles, coinsurance or
45 other cost sharing in relation to benefits for hospital lengths of stay in

1 connection with childbirth for a mother or a newborn child under the policy,
2 except that any coinsurance or other cost sharing for any portion of a period
3 within a hospital length of stay required pursuant to subsection B of this
4 section shall not be greater than the coinsurance or cost sharing for any
5 preceding portion of that stay.

6 3. Prevents an insurer from negotiating the level and type of
7 reimbursement with a provider for care provided in accordance with
8 subsection B of this section.

9 D. Any contract that provides coverage for diabetes shall also
10 provide coverage for equipment and supplies that are medically necessary and
11 that are prescribed by a health care provider including:

12 1. Blood glucose monitors.

13 2. Blood glucose monitors for the legally blind.

14 3. Test strips for glucose monitors and visual reading and urine
15 testing strips.

16 4. Insulin preparations and glucagon.

17 5. Insulin cartridges.

18 6. Drawing up devices and monitors for the visually impaired.

19 7. Injection aids.

20 8. Insulin cartridges for the legally blind.

21 9. Syringes and lancets including automatic lancing devices.

22 10. Prescribed oral agents for controlling blood sugar that are
23 included on the plan formulary.

24 11. To the extent coverage is required under medicare, podiatric
25 appliances for prevention of complications associated with diabetes.

26 12. Any other device, medication, equipment or supply for which
27 coverage is required under medicare from and after January 1, 1999. The
28 coverage required in this paragraph is effective six months after the
29 coverage is required under medicare.

30 E. Nothing in subsection D of this section prohibits a group
31 disability insurer from imposing deductibles, coinsurance or other cost
32 sharing in relation to benefits for equipment or supplies for the treatment
33 of diabetes.

34 F. Any contract that provides coverage for prescription drugs shall
35 not limit or exclude coverage for any prescription drug prescribed for the
36 treatment of cancer on the basis that the prescription drug has not been
37 approved by the United States food and drug administration for the treatment
38 of the specific type of cancer for which the prescription drug has been
39 prescribed, if the prescription drug has been recognized as safe and
40 effective for treatment of that specific type of cancer in one or more of the
41 standard medical reference compendia prescribed in subsection G of this
42 section or medical literature that meets the criteria prescribed in
43 subsection G of this section. The coverage required under this subsection
44 includes covered medically necessary services associated with the
45 administration of the prescription drug. This subsection does not:

1 1. Require coverage of any prescription drug used in the treatment of
2 a type of cancer if the United States food and drug administration has
3 determined that the prescription drug is contraindicated for that type of
4 cancer.

5 2. Require coverage for any experimental prescription drug that is
6 not approved for any indication by the United States food and drug
7 administration.

8 3. Alter any law with regard to provisions that limit the coverage of
9 prescription drugs that have not been approved by the United States food and
10 drug administration.

11 4. Require reimbursement or coverage for any prescription drug that
12 is not included in the drug formulary or list of covered prescription drugs
13 specified in the contract.

14 5. Prohibit a contract from limiting or excluding coverage of a
15 prescription drug, if the decision to limit or exclude coverage of the
16 prescription drug is not based primarily on the coverage of prescription
17 drugs required by this section.

18 6. Prohibit the use of deductibles, coinsurance, copayments or other
19 cost sharing in relation to drug benefits and related medical benefits
20 offered.

21 G. For the purposes of subsection F of this section:

22 1. The acceptable standard medical reference compendia are the
23 following:

24 (a) The American medical association drug evaluations, a publication
25 of the American medical association.

26 (b) The American hospital formulary service drug information, a
27 publication of the American society of health system pharmacists.

28 (c) Drug information for the health care provider, a publication of
29 the United States pharmacopoeia convention.

30 2. Medical literature may be accepted if all of the following apply:

31 (a) At least two articles from major peer reviewed professional
32 medical journals have recognized, based on scientific or medical criteria,
33 the drug's safety and effectiveness for treatment of the indication for which
34 the drug has been prescribed.

35 (b) No article from a major peer reviewed professional medical
36 journal has concluded, based on scientific or medical criteria, that the drug
37 is unsafe or ineffective or that the drug's safety and effectiveness cannot
38 be determined for the treatment of the indication for which the drug has been
39 prescribed.

40 (c) The literature meets the uniform requirements for manuscripts
41 submitted to biomedical journals established by the international committee
42 of medical journal editors or is published in a journal specified by the
43 United States department of health and human services as acceptable peer
44 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
45 security act (42 United States Code section 1395x(t)(2)(B)).

1 H. Any contract that is offered by a group disability insurer and
2 that contains a prescription drug benefit shall provide coverage of medical
3 foods to treat inherited metabolic disorders as provided by this section.

4 I. The metabolic disorders triggering medical foods coverage under
5 this section shall:

6 1. Be part of the newborn screening program prescribed in section
7 36-694.

8 2. Involve amino acid, carbohydrate or fat metabolism.

9 3. Have medically standard methods of diagnosis, treatment and
10 monitoring including quantification of metabolites in blood, urine or spinal
11 fluid or enzyme or DNA confirmation in tissues.

12 4. Require specially processed or treated medical foods that are
13 generally available only under the supervision and direction of a physician
14 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed
15 throughout life and without which the person may suffer serious mental or
16 physical impairment.

17 J. Medical foods eligible for coverage under this section shall be
18 prescribed or ordered under the supervision of a physician licensed pursuant
19 to title 32, chapter 13 or 17 as medically necessary for the therapeutic
20 treatment of an inherited metabolic disease.

21 K. An insurer shall cover at least fifty per cent of the cost of
22 medical foods prescribed to treat inherited metabolic disorders and covered
23 pursuant to this section. An insurer may limit the maximum annual benefit
24 for medical foods under this section to five thousand dollars, which applies
25 to the cost of all prescribed modified low protein foods and metabolic
26 formula.

27 L. ANY GROUP DISABILITY POLICY THAT PROVIDES COVERAGE FOR:

28 1. PRESCRIPTION DRUGS SHALL ALSO PROVIDE COVERAGE FOR ANY PRESCRIBED
29 DRUG OR DEVICE THAT IS APPROVED BY THE UNITED STATES FOOD AND DRUG
30 ADMINISTRATION FOR USE AS A CONTRACEPTIVE. A GROUP DISABILITY INSURER MAY
31 USE A DRUG FORMULARY, MULTITIERED DRUG FORMULARY OR LIST BUT THAT FORMULARY
32 OR LIST SHALL INCLUDE ORAL, IMPLANT AND INJECTABLE CONTRACEPTIVE DRUGS,
33 INTRAUTERINE DEVICES AND PRESCRIPTION BARRIER METHODS IF THE GROUP DISABILITY
34 INSURER DOES NOT IMPOSE DEDUCTIBLES, COINSURANCE, COPAYMENTS OR OTHER COST
35 CONTAINMENT MEASURES FOR CONTRACEPTIVE DRUGS THAT ARE GREATER THAN THE
36 DEDUCTIBLES, COINSURANCE, COPAYMENTS OR OTHER COST CONTAINMENT MEASURES FOR
37 OTHER DRUGS ON THE SAME LEVEL OF THE FORMULARY OR LIST.

38 2. OUTPATIENT HEALTH CARE SERVICES SHALL ALSO PROVIDE COVERAGE FOR
39 OUTPATIENT CONTRACEPTIVE SERVICES. FOR THE PURPOSES OF THIS PARAGRAPH,
40 "OUTPATIENT CONTRACEPTIVE SERVICES" MEANS CONSULTATIONS, EXAMINATIONS,
41 PROCEDURES AND MEDICAL SERVICES PROVIDED ON AN OUTPATIENT BASIS AND RELATED
42 TO THE USE OF UNITED STATES FOOD AND DRUG PRESCRIPTION CONTRACEPTIVE METHODS
43 TO PREVENT UNINTENDED PREGNANCIES.

44 M. NOTWITHSTANDING SUBSECTION L OF THIS SECTION, A RELIGIOUS EMPLOYER
45 WHOSE RELIGIOUS TENETS PROHIBIT THE USE OF PRESCRIBED CONTRACEPTIVE METHODS

1 MAY REQUIRE THAT THE INSURER PROVIDE A GROUP DISABILITY POLICY WITHOUT
2 COVERAGE FOR ALL FEDERAL FOOD AND DRUG ADMINISTRATION APPROVED CONTRACEPTIVE
3 METHODS. A RELIGIOUS EMPLOYER SHALL SUBMIT A WRITTEN AFFIDAVIT TO THE
4 INSURER STATING THAT IT IS A RELIGIOUS EMPLOYER. ON RECEIPT OF THE
5 AFFIDAVIT, THE INSURER SHALL ISSUE TO THE RELIGIOUS EMPLOYER A GROUP
6 DISABILITY POLICY THAT EXCLUDES COVERAGE OF PRESCRIPTION CONTRACEPTIVE
7 METHODS. THE INSURER SHALL RETAIN THE AFFIDAVIT FOR THE DURATION OF THE
8 GROUP DISABILITY POLICY AND ANY RENEWALS OF THE POLICY. BEFORE A POLICY IS
9 ISSUED, EVERY RELIGIOUS EMPLOYER THAT INVOKES THIS EXEMPTION SHALL PROVIDE
10 PROSPECTIVE INSURED WRITTEN NOTICE THAT THE RELIGIOUS EMPLOYER REFUSES TO
11 COVER ALL FEDERAL FOOD AND DRUG ADMINISTRATION APPROVED CONTRACEPTIVE METHODS
12 FOR RELIGIOUS REASONS. THIS SUBSECTION SHALL NOT EXCLUDE COVERAGE FOR
13 PRESCRIPTION CONTRACEPTIVE METHODS ORDERED BY A HEALTH CARE PROVIDER WITH
14 PRESCRIPTIVE AUTHORITY FOR MEDICAL INDICATIONS OTHER THAN TO PREVENT AN
15 UNINTENDED PREGNANCY. AN INSURER MAY REQUIRE THE INSURED TO FIRST PAY FOR
16 THE PRESCRIPTION AND THEN SUBMIT A CLAIM TO THE INSURER ALONG WITH EVIDENCE
17 THAT THE PRESCRIPTION IS FOR A NONCONTRACEPTIVE PURPOSE. AN INSURER MAY
18 CHARGE AN ADMINISTRATIVE FEE FOR HANDLING THESE CLAIMS. A RELIGIOUS EMPLOYER
19 SHALL NOT DISCRIMINATE AGAINST AN EMPLOYEE WHO INDEPENDENTLY CHOOSES TO
20 OBTAIN INSURANCE COVERAGE OR PRESCRIPTIONS FOR CONTRACEPTIVES FROM ANOTHER
21 SOURCE.

22 t. N. For the purposes of:

23 1. This section:

24 (a) "Inherited metabolic disorder" means a disease caused by an
25 inherited abnormality of body chemistry and includes a disease tested under
26 the newborn screening program prescribed in section 36-694.

27 (b) "Medical foods" means modified low protein foods and metabolic
28 formula.

29 (c) "Metabolic formula" means foods that are all of the following:

30 (i) Formulated to be consumed or administered enterally under the
31 supervision of a physician who is licensed pursuant to title 32, chapter 13
32 or 17.

33 (ii) Processed or formulated to be deficient in one or more of the
34 nutrients present in typical foodstuffs.

35 (iii) Administered for the medical and nutritional management of a
36 person who has limited capacity to metabolize foodstuffs or certain nutrients
37 contained in the foodstuffs or who has other specific nutrient requirements
38 as established by medical evaluation.

39 (iv) Essential to a person's optimal growth, health and metabolic
40 homeostasis.

41 (d) "Modified low protein foods" means foods that are all of the
42 following:

43 (i) Formulated to be consumed or administered enterally under the
44 supervision of a physician who is licensed pursuant to title 32, chapter 13
45 or 17.

1 (ii) Processed or formulated to contain less than one gram of protein
2 per unit of serving, but does not include a natural food that is naturally
3 low in protein.

4 (iii) Administered for the medical and nutritional management of a
5 person who has limited capacity to metabolize foodstuffs or certain nutrients
6 contained in the foodstuffs or who has other specific nutrient requirements
7 as established by medical evaluation.

8 (iv) Essential to a person's optimal growth, health and metabolic
9 homeostasis.

10 2. Subsection A of this section, the term "child", for purposes of
11 initial coverage of an adopted child or a child placed for adoption but not
12 for purposes of termination of coverage of such child, means a person under
13 the age of eighteen years.

14 3. SUBSECTION M OF THIS SECTION, "RELIGIOUS EMPLOYER" MEANS AN ENTITY
15 FOR WHICH ALL OF THE FOLLOWING APPLY:

16 (a) THE ENTITY PRIMARILY EMPLOYS PERSONS WHO SHARE THE RELIGIOUS
17 TENETS OF THE ENTITY.

18 (b) THE ENTITY SERVES PRIMARILY PERSONS WHO SHARE THE RELIGIOUS TENETS
19 OF THE ENTITY.

20 (c) THE ENTITY IS A NONPROFIT ORGANIZATION AS DESCRIBED IN SECTION
21 6033(a)(2)(A)i OR iii OF THE INTERNAL REVENUE CODE OF 1986, AS AMENDED.

22 Sec. 4. Section 20-1404, Arizona Revised Statutes, is amended to read:
23 20-1404. Blanket disability insurance; definitions

24 A. Blanket disability insurance is that form of disability insurance
25 covering special groups of persons as enumerated in one of the following
26 paragraphs:

27 1. Under a policy or contract issued to any common carrier, which
28 shall be deemed the policyholder, covering a group defined as all persons who
29 may become passengers on such common carrier.

30 2. Under a policy or contract issued to an employer, who shall be
31 deemed the policyholder, covering all employees or any group of employees
32 defined by reference to exceptional hazards incident to such employment.
33 Dependents of the employees and guests of the employer may also be included
34 where exposed to the same hazards.

35 3. Under a policy or contract issued to a college, school or other
36 institution of learning or to the head or principal thereof, who or which
37 shall be deemed the policyholder, covering students or teachers.

38 4. Under a policy or contract issued in the name of any volunteer fire
39 department or first aid or other such volunteer group, or agency having
40 jurisdiction thereof, which shall be deemed the policyholder, covering all
41 of the members of such fire department or group.

42 5. Under a policy or contract issued to a creditor, who shall be
43 deemed the policyholder, to insure debtors of the creditor.

1 6. Under a policy or contract issued to a sports team or to a camp or
2 sponsor thereof, which team or camp or sponsor thereof shall be deemed the
3 policyholder, covering members or campers.

4 7. Under a policy or contract that is issued to any other
5 substantially similar group and that, in the discretion of the director, may
6 be subject to the issuance of a blanket disability policy or contract.

7 B. An individual application need not be required from a person
8 covered under a blanket disability policy or contract, nor shall it be
9 necessary for the insurer to furnish each person with a certificate.

10 C. All benefits under any blanket disability policy shall be payable
11 to the person insured, or to the insured's designated beneficiary or
12 beneficiaries, or to the insured's estate, except that if the person insured
13 is a minor, such benefits may be made payable to the insured's parent or
14 guardian or any other person actually supporting the insured, and except that
15 the policy may provide that all or any portion of any indemnities provided
16 by any such policy on account of hospital, nursing, medical or surgical
17 services may, at the insurer's option, be paid directly to the hospital or
18 person rendering such services, but the policy may not require that the
19 service be rendered by a particular hospital or person. Payment so made
20 shall discharge the insurer's obligation with respect to the amount of
21 insurance so paid.

22 D. Nothing contained in this section shall be deemed to affect the
23 legal liability of policyholders for the death of or injury to any member of
24 the group.

25 E. Any policy or contract, except accidental death and dismemberment,
26 applied for that provides family coverage shall, as to such coverage of
27 family members, also provide that the benefits applicable for children shall
28 be payable with respect to a newly born child of the insured from the instant
29 of such child's birth, to a child adopted by the insured, regardless of the
30 age at which the child was adopted, and to a child who has been placed for
31 adoption with the insured and for whom the application and approval
32 procedures for adoption pursuant to section 8-105 or 8-108 have been
33 completed to the same extent that such coverage applies to other members of
34 the family. The coverage for newly born or adopted children or children
35 placed for adoption shall include coverage of injury or sickness including
36 necessary care and treatment of medically diagnosed congenital defects and
37 birth abnormalities. If payment of a specific premium is required to provide
38 coverage for a child, the policy or contract may require that notification
39 of birth, adoption or adoption placement of the child and payment of the
40 required premium must be furnished to the insurer within thirty-one days
41 after the date of birth, adoption or adoption placement in order to have the
42 coverage continue beyond the thirty-one day period.

43 F. Each policy or contract shall be so written that the insurer shall
44 pay benefits:

1 1. For performance of any surgical service that is covered by the
2 terms of such contract, regardless of the place of service.

3 2. For any home health services that are performed by a licensed home
4 health agency and that a physician has prescribed in lieu of hospital
5 services, as defined by the director, providing the hospital services would
6 have been covered.

7 3. For any diagnostic service that a physician has performed outside
8 a hospital in lieu of inpatient service, providing the inpatient service
9 would have been covered.

10 4. For any service performed in a hospital's outpatient department or
11 in a freestanding surgical facility, providing such service would have been
12 covered if performed as an inpatient service.

13 G. A blanket disability insurance policy that provides coverage for
14 the surgical expense of a mastectomy shall also provide coverage incidental
15 to the patient's covered mastectomy for the expense of reconstructive surgery
16 of the breast on which the mastectomy was performed, surgery and
17 reconstruction of the other breast to produce a symmetrical appearance,
18 prostheses, treatment of physical complications for all stages of the
19 mastectomy, including lymphedemas, and at least two external postoperative
20 prostheses subject to all of the terms and conditions of the policy.

21 H. A contract that provides coverage for surgical services for a
22 mastectomy shall also provide coverage for mammography screening performed
23 on dedicated equipment for diagnostic purposes on referral by a patient's
24 physician, subject to all of the terms and conditions of the policy and
25 according to the following guidelines:

26 1. A baseline mammogram for a woman from age thirty-five to
27 thirty-nine.

28 2. A mammogram for a woman from age forty to forty-nine every two
29 years or more frequently based on the recommendation of the woman's
30 physician.

31 3. A mammogram every year for a woman fifty years of age and over.

32 I. Any contract that is issued to the insured and that provides
33 coverage for maternity benefits shall also provide that the maternity
34 benefits apply to the costs of the birth of any child legally adopted by the
35 insured if all the following are true:

36 1. The child is adopted within one year of birth.

37 2. The insured is legally obligated to pay the costs of birth.

38 3. All preexisting conditions and other limitations have been met by
39 the insured.

40 4. The insured has notified the insurer of his acceptability to adopt
41 children pursuant to section 8-105, within sixty days after such approval or
42 within sixty days after a change in insurance policies, plans or companies.

43 J. The coverage prescribed by subsection I of this section is excess
44 to any other coverage the natural mother may have for maternity benefits
45 except coverage made available to persons pursuant to title 36, chapter 29,

1 but not including coverage made available to persons defined as eligible
2 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If
3 such other coverage exists the agency, attorney or individual arranging the
4 adoption shall make arrangements for the insurance to pay those costs that
5 may be covered under that policy and shall advise the adopting parent in
6 writing of the existence and extent of the coverage without disclosing any
7 confidential information such as the identity of the natural parent. The
8 insured adopting parents shall notify their insurer of the existence and
9 extent of the other coverage.

10 K. Any contract that provides maternity benefits shall not restrict
11 benefits for any hospital length of stay in connection with childbirth for
12 the mother or the newborn child to less than forty-eight hours following a
13 normal vaginal delivery or ninety-six hours following a cesarean section. The
14 contract shall not require the provider to obtain authorization from the
15 insurer for prescribing the minimum length of stay required by this
16 subsection. The contract may provide that an attending provider in
17 consultation with the mother may discharge the mother or the newborn child
18 before the expiration of the minimum length of stay required by this
19 subsection. The insurer shall not:

20 1. Deny the mother or the newborn child eligibility or continued
21 eligibility to enroll or to renew coverage under the terms of the contract
22 solely for the purpose of avoiding the requirements of this subsection.

23 2. Provide monetary payments or rebates to mothers to encourage those
24 mothers to accept less than the minimum protections available pursuant to
25 this subsection.

26 3. Penalize or otherwise reduce or limit the reimbursement of an
27 attending provider because that provider provided care to any insured under
28 the contract in accordance with this subsection.

29 4. Provide monetary or other incentives to an attending provider to
30 induce that provider to provide care to an insured under the contract in a
31 manner that is inconsistent with this subsection.

32 5. Except as described in subsection L of this section, restrict
33 benefits for any portion of a period within the minimum length of stay in a
34 manner that is less favorable than the benefits provided for any preceding
35 portion of that stay.

36 L. Nothing in subsection K of this section:

37 1. Requires a mother to give birth in a hospital or to stay in the
38 hospital for a fixed period of time following the birth of the child.

39 2. Prevents an insurer from imposing deductibles, coinsurance or other
40 cost sharing in relation to benefits for hospital lengths of stay in
41 connection with childbirth for a mother or a newborn child under the
42 contract, except that any coinsurance or other cost sharing for any portion
43 of a period within a hospital length of stay required pursuant to subsection
44 K of this section shall not be greater than the coinsurance or cost sharing
45 for any preceding portion of that stay.

1 3. Prevents an insurer from negotiating the level and type of
2 reimbursement with a provider for care provided in accordance with subsection
3 K of this section.

4 M. Any contract that provides coverage for diabetes shall also provide
5 coverage for equipment and supplies that are medically necessary and that are
6 prescribed by a health care provider including:

7 1. Blood glucose monitors.
8 2. Blood glucose monitors for the legally blind.
9 3. Test strips for glucose monitors and visual reading and urine
10 testing strips.

11 4. Insulin preparations and glucagon.

12 5. Insulin cartridges.

13 6. Drawing up devices and monitors for the visually impaired.

14 7. Injection aids.

15 8. Insulin cartridges for the legally blind.

16 9. Syringes and lancets including automatic lancing devices.

17 10. Prescribed oral agents for controlling blood sugar that are
18 included on the plan formulary.

19 11. To the extent coverage is required under medicare, podiatric
20 appliances for prevention of complications associated with diabetes.

21 12. Any other device, medication, equipment or supply for which
22 coverage is required under medicare from and after January 1, 1999. The
23 coverage required in this paragraph is effective six months after the
24 coverage is required under medicare.

25 N. Nothing in subsection M of this section prohibits a blanket
26 disability insurer from imposing deductibles, coinsurance or other cost
27 sharing in relation to benefits for equipment or supplies for the treatment
28 of diabetes.

29 O. Any contract that provides coverage for prescription drugs shall
30 not limit or exclude coverage for any prescription drug prescribed for the
31 treatment of cancer on the basis that the prescription drug has not been
32 approved by the United States food and drug administration for the treatment
33 of the specific type of cancer for which the prescription drug has been
34 prescribed, if the prescription drug has been recognized as safe and
35 effective for treatment of that specific type of cancer in one or more of the
36 standard medical reference compendia prescribed in subsection P of this
37 section or medical literature that meets the criteria prescribed in
38 subsection P of this section. The coverage required under this subsection
39 includes covered medically necessary services associated with the
40 administration of the prescription drug. This subsection does not:

41 1. Require coverage of any prescription drug used in the treatment of
42 a type of cancer if the United States food and drug administration has
43 determined that the prescription drug is contraindicated for that type of
44 cancer.

1 2. Require coverage for any experimental prescription drug that is not
2 approved for any indication by the United States food and drug
3 administration.

4 3. Alter any law with regard to provisions that limit the coverage of
5 prescription drugs that have not been approved by the United States food and
6 drug administration.

7 4. Require reimbursement or coverage for any prescription drug that
8 is not included in the drug formulary or list of covered prescription drugs
9 specified in the contract.

10 5. Prohibit a contract from limiting or excluding coverage of a
11 prescription drug, if the decision to limit or exclude coverage of the
12 prescription drug is not based primarily on the coverage of prescription
13 drugs required by this section.

14 6. Prohibit the use of deductibles, coinsurance, copayments or other
15 cost sharing in relation to drug benefits and related medical benefits
16 offered.

17 P. For the purposes of subsection 0 of this section:

18 1. The acceptable standard medical reference compendia are the
19 following:

20 (a) The American medical association drug evaluations, a publication
21 of the American medical association.

22 (b) The American hospital formulary service drug information, a
23 publication of the American society of health system pharmacists.

24 (c) Drug information for the health care provider, a publication of
25 the United States pharmacopoeia convention.

26 2. Medical literature may be accepted if all of the following apply:

27 (a) At least two articles from major peer reviewed professional
28 medical journals have recognized, based on scientific or medical criteria,
29 the drug's safety and effectiveness for treatment of the indication for which
30 the drug has been prescribed.

31 (b) No article from a major peer reviewed professional medical journal
32 has concluded, based on scientific or medical criteria, that the drug is
33 unsafe or ineffective or that the drug's safety and effectiveness cannot be
34 determined for the treatment of the indication for which the drug has been
35 prescribed.

36 (c) The literature meets the uniform requirements for manuscripts
37 submitted to biomedical journals established by the international committee
38 of medical journal editors or is published in a journal specified by the
39 United States department of health and human services as acceptable peer
40 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
41 security act (42 United States Code section 1395x(t)(2)(B)).

42 Q. Any contract that is offered by a blanket disability insurer and
43 that contains a prescription drug benefit shall provide coverage of medical
44 foods to treat inherited metabolic disorders as provided by this section.

1 R. The metabolic disorders triggering medical foods coverage under
2 this section shall:

3 1. Be part of the newborn screening program prescribed in section
4 36-694.

5 2. Involve amino acid, carbohydrate or fat metabolism.

6 3. Have medically standard methods of diagnosis, treatment and
7 monitoring including quantification of metabolites in blood, urine or spinal
8 fluid or enzyme or DNA confirmation in tissues.

9 4. Require specially processed or treated medical foods that are
10 generally available only under the supervision and direction of a physician
11 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed
12 throughout life and without which the person may suffer serious mental or
13 physical impairment.

14 S. Medical foods eligible for coverage under this section shall be
15 prescribed or ordered under the supervision of a physician licensed pursuant
16 to title 32, chapter 13 or 17 as medically necessary for the therapeutic
17 treatment of an inherited metabolic disease.

18 T. An insurer shall cover at least fifty per cent of the cost of
19 medical foods prescribed to treat inherited metabolic disorders and covered
20 pursuant to this section. An insurer may limit the maximum annual benefit
21 for medical foods under this section to five thousand dollars which applies
22 to the cost of all prescribed modified low protein foods and metabolic
23 formula.

24 U. ANY BLANKET DISABILITY POLICY THAT PROVIDES COVERAGE FOR:

25 1. PRESCRIPTION DRUGS SHALL ALSO PROVIDE COVERAGE FOR ANY PRESCRIBED
26 DRUG OR DEVICE THAT IS APPROVED BY THE UNITED STATES FOOD AND DRUG
27 ADMINISTRATION FOR USE AS A CONTRACEPTIVE. A BLANKET DISABILITY INSURER MAY
28 USE A DRUG FORMULARY, MULTITIERED DRUG FORMULARY OR LIST BUT THAT FORMULARY
29 OR LIST SHALL INCLUDE ORAL, IMPLANT AND INJECTABLE CONTRACEPTIVE DRUGS,
30 INTRAUTERINE DEVICES AND PRESCRIPTION BARRIER METHODS IF THE BLANKET
31 DISABILITY INSURER DOES NOT IMPOSE DEDUCTIBLES, COINSURANCE, CO-PAYMENTS OR
32 OTHER COST CONTAINMENT MEASURES FOR CONTRACEPTIVE DRUGS THAT ARE GREATER THAN
33 THE DEDUCTIBLES, COINSURANCE, CO-PAYMENTS OR OTHER COST CONTAINMENT MEASURES
34 FOR OTHER DRUGS ON THE SAME LEVEL OF THE FORMULARY OR LIST.

35 2. OUTPATIENT HEALTH CARE SERVICES SHALL ALSO PROVIDE COVERAGE FOR
36 OUTPATIENT CONTRACEPTIVE SERVICES. FOR THE PURPOSES OF THIS PARAGRAPH,
37 "OUTPATIENT CONTRACEPTIVE SERVICES" MEANS CONSULTATIONS, EXAMINATIONS,
38 PROCEDURES AND MEDICAL SERVICES PROVIDED ON AN OUTPATIENT BASIS AND RELATED
39 TO THE USE OF UNITED STATES FOOD AND DRUG PRESCRIPTION CONTRACEPTIVE METHODS
40 TO PREVENT UNINTENDED PREGNANCIES.

41 V. NOTWITHSTANDING SUBSECTION U OF THIS SECTION, A RELIGIOUS EMPLOYER
42 WHOSE RELIGIOUS TENETS PROHIBIT THE USE OF PRESCRIBED CONTRACEPTIVE METHODS
43 MAY REQUIRE THAT THE INSURER PROVIDE A BLANKET DISABILITY POLICY WITHOUT
44 COVERAGE FOR ALL FEDERAL FOOD AND DRUG ADMINISTRATION APPROVED CONTRACEPTIVE
45 METHODS. A RELIGIOUS EMPLOYER SHALL SUBMIT A WRITTEN AFFIDAVIT TO THE

1 INSURER STATING THAT IT IS A RELIGIOUS EMPLOYER. ON RECEIPT OF THE
2 AFFIDAVIT, THE INSURER SHALL ISSUE TO THE RELIGIOUS EMPLOYER A BLANKET
3 DISABILITY POLICY THAT EXCLUDES COVERAGE OF PRESCRIPTION CONTRACEPTIVE
4 METHODS. THE INSURER SHALL RETAIN THE AFFIDAVIT FOR THE DURATION OF THE
5 BLANKET DISABILITY POLICY AND ANY RENEWALS OF THE POLICY. BEFORE A POLICY
6 IS ISSUED, EVERY RELIGIOUS EMPLOYER THAT INVOKES THIS EXEMPTION SHALL PROVIDE
7 PROSPECTIVE INSUREDS WRITTEN NOTICE THAT THE RELIGIOUS EMPLOYER REFUSES TO
8 COVER ALL FEDERAL FOOD AND DRUG ADMINISTRATION APPROVED CONTRACEPTIVE METHODS
9 FOR RELIGIOUS REASONS. THIS SUBSECTION SHALL NOT EXCLUDE COVERAGE FOR
10 PRESCRIPTION CONTRACEPTIVE METHODS ORDERED BY A HEALTH CARE PROVIDER WITH
11 PRESCRIPTIVE AUTHORITY FOR MEDICAL INDICATIONS OTHER THAN TO PREVENT AN
12 UNINTENDED PREGNANCY. AN INSURER MAY REQUIRE THE INSURED TO FIRST PAY FOR
13 THE PRESCRIPTION AND THEN SUBMIT A CLAIM TO THE INSURER ALONG WITH EVIDENCE
14 THAT THE PRESCRIPTION IS FOR A NONCONTRACEPTIVE PURPOSE. AN INSURER MAY
15 CHARGE AN ADMINISTRATIVE FEE FOR HANDLING THESE CLAIMS UNDER THIS
16 PARAGRAPH. A RELIGIOUS EMPLOYER SHALL NOT DISCRIMINATE AGAINST AN EMPLOYEE
17 WHO INDEPENDENTLY CHOOSES TO OBTAIN INSURANCE COVERAGE OR PRESCRIPTIONS FOR
18 CONTRACEPTIVES FROM ANOTHER SOURCE.

19 ~~U.~~ W. For the purposes of:

20 1. This section:

21 (a) "Inherited metabolic disorder" means a disease caused by an
22 inherited abnormality of body chemistry and includes a disease tested under
23 the newborn screening program prescribed in section 36-694.

24 (b) "Medical foods" means modified low protein foods and metabolic
25 formula.

26 (c) "Metabolic formula" means foods that are all of the following:

27 (i) Formulated to be consumed or administered enterally under the
28 supervision of a physician who is licensed pursuant to title 32, chapter 13
29 or 17.

30 (ii) Processed or formulated to be deficient in one or more of the
31 nutrients present in typical foodstuffs.

32 (iii) Administered for the medical and nutritional management of a
33 person who has limited capacity to metabolize foodstuffs or certain nutrients
34 contained in the foodstuffs or who has other specific nutrient requirements
35 as established by medical evaluation.

36 (iv) Essential to a person's optimal growth, health and metabolic
37 homeostasis.

38 (d) "Modified low protein foods" means foods that are all of the
39 following:

40 (i) Formulated to be consumed or administered enterally under the
41 supervision of a physician who is licensed pursuant to title 32, chapter 13
42 or 17.

43 (ii) Processed or formulated to contain less than one gram of protein
44 per unit of serving, but does not include a natural food that is naturally
45 low in protein.

1 (iii) Administered for the medical and nutritional management of a
2 person who has limited capacity to metabolize foodstuffs or certain nutrients
3 contained in the foodstuffs or who has other specific nutrient requirements
4 as established by medical evaluation.

5 (iv) Essential to a person's optimal growth, health and metabolic
6 homeostasis.

7 2. Subsection E of this section, the term "child", for purposes of
8 initial coverage of an adopted child or a child placed for adoption but not
9 for purposes of termination of coverage of such child, means a person under
10 the age of eighteen years.

11 3. SUBSECTION V OF THIS SECTION, "RELIGIOUS EMPLOYER" MEANS AN ENTITY
12 FOR WHICH ALL OF THE FOLLOWING APPLY:

13 (a) THE ENTITY PRIMARILY EMPLOYS PERSONS WHO SHARE THE RELIGIOUS
14 TENETS OF THE ENTITY.

15 (b) THE ENTITY SERVES PRIMARILY PERSONS WHO SHARE THE RELIGIOUS TENETS
16 OF THE ENTITY.

17 (c) THE ENTITY IS A NONPROFIT ORGANIZATION AS DESCRIBED IN SECTION
18 6033(a)(2)(A)i OR iii OF THE INTERNAL REVENUE CODE OF 1986, AS AMENDED.

19 Sec. 5. Title 20, chapter 13, article 1, Arizona Revised Statutes, is
20 amended by adding section 20-2329, to read:

21 20-2329. Prescription contraceptive drugs and devices;
22 definition

23 A. AN ACCOUNTABLE HEALTH PLAN THAT PROVIDES A HEALTH BENEFITS PLAN
24 THAT PROVIDES COVERAGE FOR:

25 1. PRESCRIPTION DRUGS SHALL ALSO PROVIDE COVERAGE FOR ANY PRESCRIBED
26 DRUG OR DEVICE THAT IS APPROVED BY THE UNITED STATES FOOD AND DRUG
27 ADMINISTRATION FOR USE AS A CONTRACEPTIVE. AN ACCOUNTABLE HEALTH PLAN MAY
28 USE A DRUG FORMULARY, MULTITIERED DRUG FORMULARY OR LIST BUT THAT FORMULARY
29 OR LIST SHALL INCLUDE ORAL, IMPLANT AND INJECTABLE CONTRACEPTIVE DRUGS,
30 INTRAUTERINE DEVICES AND PRESCRIPTION BARRIER METHODS IF THE ACCOUNTABLE
31 HEALTH PLAN DOES NOT IMPOSE DEDUCTIBLES, COINSURANCE, COPAYMENTS OR OTHER
32 COST CONTAINMENT MEASURES FOR CONTRACEPTIVE DRUGS THAT ARE GREATER THAN THE
33 DEDUCTIBLES, COINSURANCE, COPAYMENTS OR OTHER COST CONTAINMENT MEASURES FOR
34 OTHER DRUGS ON THE SAME LEVEL OF THE FORMULARY OR LIST.

35 2. OUTPATIENT HEALTH CARE SERVICES SHALL ALSO PROVIDE COVERAGE FOR
36 OUTPATIENT CONTRACEPTIVE SERVICES. FOR THE PURPOSES OF THIS PARAGRAPH,
37 "OUTPATIENT CONTRACEPTIVE SERVICES" MEANS CONSULTATIONS, EXAMINATIONS,
38 PROCEDURES AND MEDICAL SERVICES PROVIDED ON AN OUTPATIENT BASIS AND RELATED
39 TO THE USE OF UNITED STATES FOOD AND DRUG PRESCRIPTION CONTRACEPTIVE METHODS
40 TO PREVENT UNINTENDED PREGNANCIES.

41 B. NOTWITHSTANDING SUBSECTION A, A RELIGIOUS EMPLOYER WHOSE RELIGIOUS
42 TENETS PROHIBIT THE USE OF PRESCRIBED CONTRACEPTIVE METHODS MAY REQUIRE THAT
43 THE ACCOUNTABLE HEALTH PLAN PROVIDE A HEALTH BENEFITS PLAN WITHOUT COVERAGE
44 FOR ALL FEDERAL FOOD AND DRUG ADMINISTRATION APPROVED CONTRACEPTIVE
45 METHODS. A RELIGIOUS EMPLOYER SHALL SUBMIT A WRITTEN AFFIDAVIT TO THE

1 ACCOUNTABLE HEALTH PLAN STATING THAT IT IS A RELIGIOUS EMPLOYER. ON RECEIPT
2 OF THE AFFIDAVIT, THE ACCOUNTABLE HEALTH PLAN SHALL ISSUE TO THE RELIGIOUS
3 EMPLOYER A HEALTH BENEFITS PLAN THAT EXCLUDES COVERAGE OF PRESCRIPTION
4 CONTRACEPTIVE METHODS. THE ACCOUNTABLE HEALTH PLAN SHALL RETAIN THE
5 AFFIDAVIT FOR THE DURATION OF THE HEALTH BENEFITS PLAN AND ANY RENEWALS OF
6 THE PLAN.

7 C. BEFORE ENROLLMENT IN THE PLAN, EVERY RELIGIOUS EMPLOYER THAT
8 INVOKES THIS EXEMPTION SHALL PROVIDE PROSPECTIVE ENROLLEES WRITTEN NOTICE
9 THAT THE RELIGIOUS EMPLOYER REFUSES TO COVER ALL FEDERAL FOOD AND DRUG
10 ADMINISTRATION APPROVED CONTRACEPTIVE METHODS FOR RELIGIOUS REASONS.

11 D. SUBSECTION B SHALL NOT EXCLUDE COVERAGE FOR PRESCRIPTION
12 CONTRACEPTIVE METHODS ORDERED BY A HEALTH CARE PROVIDER WITH PRESCRIPTIVE
13 AUTHORITY FOR MEDICAL INDICATIONS OTHER THAN TO PREVENT AN UNINTENDED
14 PREGNANCY. AN ACCOUNTABLE HEALTH PLAN MAY REQUIRE THE ENROLLEE TO FIRST PAY
15 FOR THE PRESCRIPTION AND THEN SUBMIT A CLAIM TO THE ACCOUNTABLE HEALTH PLAN
16 ALONG WITH EVIDENCE THAT THE PRESCRIPTION IS FOR A NONCONTRACEPTIVE PURPOSE.
17 AN ACCOUNTABLE HEALTH PLAN MAY CHARGE AN ADMINISTRATIVE FEE FOR HANDLING
18 CLAIMS UNDER THIS SUBSECTION.

19 E. A RELIGIOUS EMPLOYER SHALL NOT DISCRIMINATE AGAINST AN EMPLOYEE WHO
20 INDEPENDENTLY CHOOSES TO OBTAIN INSURANCE COVERAGE OR PRESCRIPTIONS FOR
21 CONTRACEPTIVES FROM ANOTHER SOURCE.

22 F. FOR THE PURPOSES OF THIS SECTION, "RELIGIOUS EMPLOYER" MEANS AN
23 ENTITY FOR WHICH ALL OF THE FOLLOWING APPLY:

24 1. THE ENTITY PRIMARILY EMPLOYS PERSONS WHO SHARE THE RELIGIOUS TENETS
25 OF THE ENTITY.

26 2. THE ENTITY SERVES PRIMARILY PERSONS WHO SHARE THE RELIGIOUS TENETS
27 OF THE ENTITY.

28 3. THE ENTITY IS A NONPROFIT ORGANIZATION AS DESCRIBED IN SECTION
29 6033(a)(2)(A)i OR iii OF THE INTERNAL REVENUE CODE OF 1986, AS AMENDED.

30 Sec. 6. Applicability

31 This act applies to contracts, policies and evidences of coverage
32 issued or renewed from and after December 31, 2002.


APPROVED BY THE GOVERNOR APRIL 21, 2002.


FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 22, 2002.

Passed the House April 2, 2002,

by the following vote: 38 Ayes,

17 Nays, 5 Not Voting

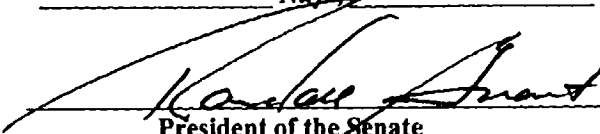

Speaker of the House

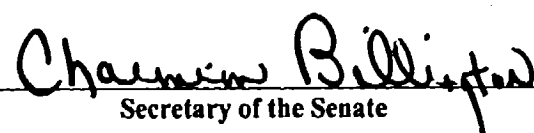

Chief Clerk of the House

Passed the Senate April 15, 2002,

by the following vote: 17 Ayes,

10 Nays, 3 Not Voting


President of the Senate

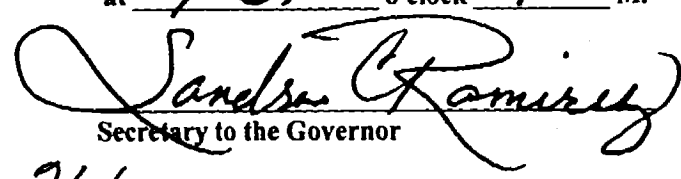

Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill was received by the Governor this

16 day of April, 2002

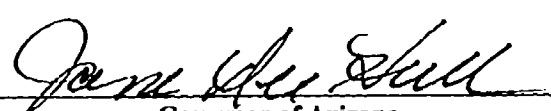
at 1:31 o'clock P M.


Secretary to the Governor

Approved this 21st day of

April, 2002,

at 5:20 o'clock P M.

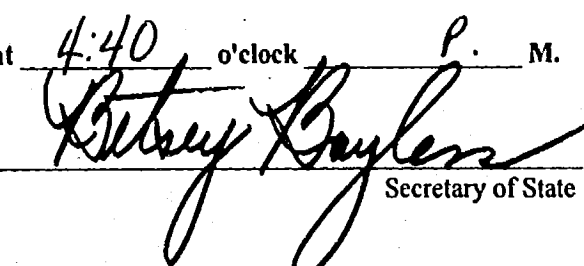

Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this 22 day of April, 2002

at 4:40 o'clock P M.


Secretary of State

H.B. 2234